AIDS and contemporary history

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Introduction AIDS and contemporary history

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There is a different historical consciousness around AIDS at the end of ten years. AIDS now has its own history, rather than borrowing from the more distant past. Surveys of the recent past, looking back over a decade, are common. There is a realisation, too, that understanding AIDS requires an assessment of the 'larger agenda' of health, social and science policy development in the post-war period. The impact of the disease cannot be assessed without knowing something of this 'pre-history'. This book is therefore framed around the twin areas of AIDS as history and the pre-history of the disease. Its concern is very much with AIDS as an issue in contemporary history and with the perspectives on the history of post-war health policy which it has revealed.

The purpose of this introductory chapter is not just to survey AIDS as a problem in contemporary history, but to reflect on the changing relationship of AIDS and history over the past ten years. For even in its early stages, the disease brought history in its train. The function of the discipline was different at that time. Much historical commentary aimed to point a 'lesson of history'. Its concern was to draw parallels with the distant past rather than to locate AIDS in its immediate pre-history. The form of history has therefore changed over time. It has shifted from far distant events to those of only a few years ago. The function of history, too, has shifted. Three functions of historical policy writing can broadly be identified: 'policy relevant' history feeding in to current policies or used in forecasting future developments; 'recreating the past' for its own sake, academic 'voyeurism' or journalism; and policy analysis, the understanding of past events according to particular theoretical models and empirical understanding, analysing the past without specific current policy intent (although the insights provided may feed into perceptions of the present). The relationship between AIDS and history has developed away from the first function, the 'lesson of history', through journalism and towards historical policy analysis. In doing so, it has brought a realisation of the strengths of the historical approach, what makes it unique and appropriate for the analysis of recent, as well as more distant, events.

AIDS, epidemic disease and the 'lesson of history'

Let us begin by tracing the 'history of AIDS and history'. The initial role of history was very much that of the first function of 'policy relevant' history. The 'lesson of history' was to the fore. The novelty and shock of a life-threatening infectious disease of potentially epidemic proportions in the late twentieth century led to a search for explanatory models from the past with some degree of predictive power. How had society reacted to and dealt with past epidemics? Could the past give a clue to the end of this particular disease story? What forms of reaction were appropriate? The initial historical input focused on three broad areas: the role of epidemic disease in past societies, in particular the association between disease and 'moral panic' or disease and stigmatised minorities; the historical record in the area of sexually transmitted disease, in particular the traditions of voluntarism and confidentiality in this area in Britain; and more general questions of ends and means in public health policy, focusing on practices such as quarantine and notification, and contributing to the classic public health debate between the rights of the individual and the good of society. Papers and collected editions on these themes proliferated.[1]

Nor was historical consciousness confined to historians. The annual international AIDS conference, an enormous gathering, early on developed a history strand amid a primarily clinical, scientific and epidemiological focus. Historians of 'relevant' areas such as cholera and plague suddenly found their work and thoughts of interest to participants in AIDS conferences, actively seeking the 'lesson of history'. This lesson was mediated by different national cultures. In France, for example, the earlier history of regulation in the area of sexually transmitted diseases was one which included central state regulation in particular of prostitution. It was this national history which entered the French debates around AIDS in the 1980s. The United States, perhaps in line with its own pluralist and federal structures, saw a plurality of competing 'lessons' around the issues of compulsion and confidentiality.[2] But in Britain the 'lesson of history' almost without exception stressed a voluntaristic, non-punitive and confidential response. The historian Roy Porter's editorial in the *British Medical Journal* in 1986 headlined 'History says no to the policeman's response to AIDS' was a high point in historical judgement on the present, drawing on analogies from the history of public health in relation to civil liberties and on the British example in the area of sexually transmitted diseases (STDs).[3]

These historical arguments were of some policy significance. Two key protagonists in early AIDS policy making in Britain, Professor Michael Adler at the Middlesex Hospital and Sir Donald Acheson, Chief Medical Officer at the Department of Health, had a keen interest in historical precedent.[4] The reports of the Chief Medical Officer in the early AIDS years were consciously historical, citing parallels between AIDS and the great nineteenth-century battles against

disease.[5] History was used both to construct and defend a liberal consensus around AIDS. The 'lesson of history' came into the debates in 1985 about whether AIDS should be made a compulsorily notifiable disease (it was not); and in the general defence of a liberal line. Acheson in his evidence to the Commons Social Services Committee hearing on AIDS in 1987 cited the historical record as a prime reason for avoiding a punitive response to AIDS.[6]

AIDS as a 'chronic disease' and history

The historical arguments and analogies were of importance in early British policy formation. AIDS was an 'open' policy area and it was possible for policy to be directly influenced in ways which would be more unusual in an established policy arena. But the early period of AIDS as an 'epidemic disease' passed and with it passed the role of epidemic history. AIDS policy development in Britain over the past decade has passed through three stages: an initial period from 1981 to 1986 of surprise and shock, with relatively little official action, succeeded in 1986–7 by a brief period of 'war-time emergency' when politicians publicly intervened and AIDS was officially established as a high level national emergency.[7] 'Epidemic history' fitted well into these initial stages and was itself an active policy force in the British context. But from 1987 onward, these two initial 'heroic' phases have been followed by a calmer period, by what has been termed the 'normalisation' of the disease and of the public reaction to it. The model of chronic rather than epidemic disease has come to the fore.[8] History has been less of an active policy force; and the historical analogies used to understand the disease have themselves changed to accommodate this change in perception. Take, for example, a piece by Charles Rosenberg in a 1989 issue of *Daedalus*. Distinctly post-heroic and post-epidemic in tone, it notes the range and stages of policy choices in an epidemic. Rosenberg cites the 'chronic disease' model of tuberculosis, which, although far more widespread in the nineteenth century, did not elicit the moral and political pressure for immediate action as did yellow fever or cholera.[9] How and why the chronic disease model came so swiftly to establish hegemony is a valid area of investigation. In policy terms AIDS was assimilated to the pre-existing dominant twentieth-century models of disease, those of chronic degenerative, not epidemic infectious disease. The work of historians played little part in challenging the hegemony of that perspective. For 'the lesson of history' in both the later and the early stages of AIDS policy development mirrored the preconceptions of the present.

'Relevant history' of this type has its dangers. In an open policy situation, the case with AIDS in the first half of the 1980s, history could play a practical rather than a symbolic role. How far that role was justified was a different matter. For what lay behind this form of historical intervention was a Whiggish assumption that there was indeed a 'lesson of history' which could be learnt, that the past

could provide a blueprint for a present-day policy reaction. Historical reaction was predicated on the assumptions of the present. The implication was that history was incontrovertible 'fact' rather than a welter of differing interpretations, themselves in turn historically specific. The belief that historical evidence was some higher form of truth, although useful in establishing particular policy positions, down-played some of its subtler strengths of analysis.

This was an approach which accorded well with the ethos of the time. In the United States, as Elizabeth Fee and Daniel Fox have commented, the study of history had seemed less relevant prior to AIDS; the revival of history as a policy science came with the disease.[10] In the UK, the situation was somewhat different. The status of history as what one commentator had called a 'profoundly ideological subject' had revived even prior to AIDS.[11] In the 1980s, the initiative had come from the right rather than the left. While history on the left, a dynamic force in the 1960s and early 70s, had often seemed on the defensive, or preoccupied with its own historiography and with internal debate, history on the right increasingly made the running in relation to practical policy issues.[12] The demand for a return to nineteenth-century 'self-help' and to 'Victorian values' and the debates round the place of history in the British schools national curriculum may be cited as particular examples. Discussion round this latter issue had also centred on the role of fact in history and the 'lesson of history' approach. In Britain, therefore, the early relationship between AIDS and history continued and extended the existing interface between policy and history. And in Europe in general, especially eastern Europe, the 'lesson of history' seemed particularly appropriate in the late 1980s as a series of revolutions overturned communist governments. In Czechoslovakia for example, radicalism was built around historical example; and parallels with the revolutions of 1848 were commonly made. In general, then, there was a heightened European sense of the historical relationships of policy change in the 1980s. Such consciousness can have its dangers. As Pat Thane has commented, it looks at events through the 'wrong end of the telescope', taking little account of the necessity of understanding past events in the very different context of their time.[13] Other historians too have commented on the dangers of 'presentism'. Hugh Trevor Roper put it baldly; historians were in danger of being 'great toadies of power', simply justifying, and not analysing, or challenging dominant perspectives.[14]

The focus of this volume is not the 'lesson of history', but a different form of historical analysis. At the end of the first decade of epidemic, different types of history have come to the fore. The notion of AIDS itself as history is more prominent and with it the potential role of the 'contemporary history' of health policy in general. Nonetheless historical analogy should not be discounted. Such historical intervention is valuable in challenging dominant preconceptions and in locating contemporary reactions in their context. As Shirley Lindenbaum has

argued, 'history as background' has a useful role to play. She has pointed, for example, to the historic specificity of stigma in relation to diseases such as leprosy; and to the 'cultural construction' of the individual liberty/public good dichotomy which is now presented as at the heart of the public health debate.[15] The particular focus of this volume is on two areas of historical analysis – the 'contemporary history' of AIDS and what we call the 'pre-history' of the disease. AIDS itself is a study in history; and the significance of almost contemporary events cannot be understood without locating them in context. We cannot assess the impact of AIDS across a whole range of policy arenas – from research policy to drug policy, from the church to the gay response – without analysing developments in post-war policy in those areas and, in particular, the issues which have been of importance since the 1960s and 70s. AIDS has underlined the lack of historical study of many areas of health and social policy in recent decades.

A growing body of work is focusing on the concept of 'AIDS as history', from a variety of different perspectives. One early example was Dennis Altman's *AIDS and the New Puritanism* (1986), which documented and analysed the early gay response to the crisis.[16] This has been joined by other histories. Gerald Oppenheimer, for example, has seen AIDS as a case study in the construction of disciplinary ownership of an issue and has analysed the role played by epidemiologists and virologists in the scientific construction of AIDS.[17] Daniel Fox, Patricia Day and Rudolf Klein have compared the development of AIDS policies in Sweden, the UK and USA.[18] The form and functions of such histories has varied – from a brief reconstruction of the early history of the Terrence Higgins Trust, to an analysis of the pre- and contemporary history (and possible future) of the Federal Drugs Agency (FDA) and drug regulation in the United States under the impact of AIDS.[19] At the end of the first decade of the disease, even ostensibly non-historical analysis routinely includes a survey of particular histories of the past decade and before. Papers on volunteering and AIDS; on doctors and AIDS patients; and on the issues for reproductive freedom raised by AIDS published in a recent volume located their analysis in the histories both of contemporary events and of preceding decades.[20] The journal *AIDS Care* had a historical survey of the past ten years as part of its tenth anniversary issue.[21] Professor Tony Coxon, a sociologist and leading AIDS researcher, introduced his remarks at an AIDS conference aimed at bringing social scientists and policy makers together with a history of the Economic and Social Research Council's involvement in the area.[22] The examples are legion.

Such reflectiveness is a natural process. The new historical face of AIDS has continued to have a number of functions; and its practitioners have also been varied. Policy relevance as well as policy analysis has continued to be the order of the day; and some surveys have adopted what Roy Porter has called a 'heroes and villains' approach, which tends to ignore the social and structural

underpinning of events. The American journalist Randy Shilts's history of the early years of the AIDS epidemic in the United States, *And the Band Played On* has been criticised for the emphasis it places on personal culpability rather than the slowness and ineptitude of the American Federal state.[23] Journalists have in fact played a particular role in writing the 'contemporary history' of AIDS. Several, both in the United States and in Britain, used their vantage point on events to produce speedy accounts of the initial crisis.[24] Other accounts have derived from a different mix of perspectives. Science and history proved a powerful combination in M. D. Grmek's *History of AIDS*.[25] Contributions have also come from sociology, from anthropology (where the interest in cultural formation and change over time has meshed with the historical approach) and from political science.[26] In Britain, the annual meeting and proceedings of the Social Aspects of AIDS conference have provided not just a vantage point for British sociology, but also a wealth of source material for contemporary history.[27] There are thus a variety of disciplinary approaches mingling in the recent history fold. Added to them is what can be termed 'activist contemporary history'. There is concern that the early dimensions of the voluntary and largely gay response, subsequently overlain by one which attracted statutory funding, which was professionalised, normalised and non-gay, may be 'hidden from history'. There has been a concern to document this early response before memories and participants are lost.[28] Such historical consciousness can also have its dangers. 'History from below' for AIDS, as more generally, runs the risk of presenting an alternative 'official history' also cast in the heroes and villains mould.[29] The 'invention of tradition' can also be a feature of the reconstruction of the recent past.

Given the incipient vitality of the field, what can historians contribute? It might indeed be asked what the particular strengths of the discipline are. Some policy scientists have stoutly maintained that the historian has no business in dabbling with contemporary events.[30] So why is AIDS a problem in contemporary history? Three broad strengths can be presented for consideration: the historian's sense of chronology; the historical sense of continuity as well as change; and, within an overall chronology, a synthetic and critical ability to interweave and assess different forms of source material and different levels of interpretation. Chronology may not be everything and much fundamental work in history cannot be done within a purely chronological framework. Nonetheless, academic history, more than any other social science, has made a disciplinary specialty of the passage of time. Another potential strength lies in the historian's implicit cynicism about the routine proclamations of a new departure in policy. Historians, more than most other social scientists, have the capacity to locate policy change in past practice, to seek out antecedents and tendencies which feed into present policy development. At its worst, this ability can prove an obsessive desire to show that nothing ever changes, to deny the

relevance of individual or collective effort. At its best, it provides a powerful means of setting policy development in its proper context. For AIDS, for example, supposedly new policies such as those in research or illegal drugs, turn out to possess deep roots in the past. The final strength of the historical approach lies in its generalising ability both in terms of methodology and of theoretical approach. The relative atheoreticity of the subject has been a matter of comment from other disciplinary standpoints. Historians certainly engage in theoretical development; but it is rare that theory overtly dominates. Herein lies a strength. For sociologists, political scientists and others can, on occasion, drown in a welter of theory grounded on a slim empirical base. The historical approach is unique in its potential ability both to deal with and assess a range of primary source material bearing on the subject, to interweave that complex story with levels of theoretical explanation – and all within a framework which takes account of the passage of time. Historical cynicism as well as sensitivity to the assessment of competing sources and accounts must be accounted strengths. No historian would accept a single account or source at face value – a besetting sin in 'policy history' accounts emanating from non-historical sources. Historians as ideologically distant as Michael Howard and Christopher Hill are agreed that it is structure and process which are important in history.[31] We need, writes Hill, 'an understanding of history as a process, not just a bran-tub full of anecdotes'.[32] The generalising nature of history is central, as is its conceptual appreciation of change.

In researching contemporary history – of AIDS or any other area – that process is not without its difficulties. There is of necessity a reliance on oral sources. Contemporary history is particularly difficult for British historians for the lack of a Freedom of Information Act inhibits access to government departments under the thirty year rule. A journalistic 'contemporary history' such as Crewdson's analysis of Robert Gallo's laboratory notebooks would be impossible in the UK; the US legislation made access possible to National Institute of Health (NIH) data.[33] In fact, few of the historical accounts beginning to emerge have used conventional historical source material. Keith Alcorn's study of the genesis of the British government's mass media response to AIDS in 1987 is one of the few British accounts to use the minutes of the relevant committees.[34] Leaving aside these problems of sources, the writing and publishing of contemporary history has its own problems – not least where living 'historical actors' disagree with historians' interpretation of events. Nonetheless, AIDS has demonstrated important and in some senses unrealised potential in the historical approach to policy issues. The papers in this volume, mostly by historians, but with a sprinkling of policy scientists and an archivist, demonstrate some of the vitality of the contemporary history of AIDS and of its historical location in the social and health policy issues of the twentieth century and especially of the post-war period. The first part of the book concentrates on

the 'larger agendas' into which AIDS fitted. Jeffrey Weeks in 'AIDS and the regulation of sexuality' locates reactions to AIDS in the history of sexuality and in particular the changing responses to sexual diversity in the post-war period. He draws attention to a complex matrix of reactions – liberalisation, but also moral confusion and a new conservatism emerging in the late 1970s and 1980s. AIDS emerged at a time when the political impetus of the UK gay movement had exhausted itself, but other strengths – a commercial subculture, self-help agencies – had emerged. This male community bound by ties of sex and of friendship was inevitably a vector for the rapid spread of the disease. But those friendship ties were also the bonds which made possible the spread of safer sex and community self-organisation. The nature of the policy response has also been complex in its relationship to the gay community. The government relied on that community to promote safe sex education while at the same time limiting sex education in schools and the promotion of homosexuality by local authorities. The same duality is apparent in the impact on the gay community, at one and the same time doubly stigmatised, yet also achieving new legitimacy and public acceptability.

AIDS fitted into that pre-history of gay politics and self-organisation; but it also fitted into other agendas. Jane Lewis in 'Public health doctors and AIDS as a public health issue' shows how AIDS' own initial definition as an 'epidemic disease' and subsequent redefinition as a chronic disease has mirrored the shift which public health doctors have been struggling to make since the late nineteenth century. They have attempted to redefine their role in a society no longer dominated by infectious disease. Public health, since the 'bacteriological revolution' of the late nineteenth century, has defined itself in terms of individual prevention, but has also seen its role very much in terms of the particular functions it has undertaken, for example hospital administration in the inter-war years. Public health, via the 1988 Acheson Report, has redefined its role again in the 1980s, this time in response to AIDS. But as Lewis argues, this 'new public health', although rooted in public health's past in theoretical terms at least, has not adopted that nineteenth-century determination to consider the social and environmental determinants of health, or to take issue with those in authority. What has continued is instead a focus on individual prevention; an intersectoral approach has failed to develop. The discipline continues to define itself around epidemiology as a means of scientific legitimacy.

AIDS has brought not just a revival of public health and the focus on epidemiology, but also revival of interest in 'testing' and surveillance. Bridget Towers in 'Politics and policy: historical perspectives on screening' shows in her analysis of past debates round 'sifting' and 'sorting', in case studies of radiography and TB; of testing for venereal diseases; of paternity testing; and the medical inspection of aliens, how the debates of the 1980s were mirrored in earlier discussions of screening. The epidemiological data thus produced tell us

more about the social operation of the service provided rather than any model of scientific and technical progress or of objective 'knowing'. Towers also raises the continuing theme of confidentiality. This arose, she demonstrates from her case studies, not just out of the individually focused doctor–patient relationship but had wider bureaucratic ramifications in terms of the empowering of groups with access to information deemed to be confidential. Confidentiality can have managerial implications, and has historically been dependent on the status of the person concerned. In discussing the question of screening for commercial purposes (most notably by insurance companies), Towers comments how the practice has been legitimated by its definition as a medical activity. Yet insurance companies as much as state bureaucracies face real potential costs.

Ilana Löwy looks in 'Testing for a sexually transmissible disease 1907–1970: the history of the Wassermann reaction' at the 'pre-history' of testing from another perspective. Integrating perspectives derived from science, history and sociology, she demonstrates the emergence and establishment of the Wassermann test for syphilis between 1906 and 1940, a test which, unbeknown to its users at the time, brought with it a high rate of false positives and consequently artificially high diagnoses of syphilis. The development of specific 'treponemal tests' and the analysis of results of mass screening for syphilis brought a reassessment of its use and specificity. For AIDS, too, the problem of the high ratio of false positives in low risk populations and the social costs of such false positives have been important arguments in debates on mandatory or large-scale AIDS testing. Other uncertainties also surround the test; and, as Löwy comments, the history of the Wassermann reaction reminds us of the fragility of apparently uncontestable 'medical facts'.

Paul Weindling in 'The politics of international co-ordination to combat sexually transmitted diseases, 1900–1980s' traces the battleground of international health as illustrated by the particular example of sexually transmitted disease. In the inter-war years the League of Nations, the International Labour Office, Red Cross and the International Office of Public Health provided the organisational bases for the complex interaction of pro-natalism and social purity movements; of feminists and pacifists. Medical science was an important legitimating source of expertise; and the League of Nations concentrated on a restricted range of scientific issues – the Wassermann test, salvarsan – and on technical input in terms of medical education. The World Health Organisation model as it developed post-1948 was a medical one and the introduction of antibiotics strengthened this tendency. Weindling points to how scientism, militarism and state controls have dominated international initiatives. The powers and responsibilities of international organisations remain unresolved, between a minimalist role as agencies of epidemiological intelligence and a universalist drive to formulate optimum standards transcending the interests of ruling elites in nation states.

Weindling's call for a blending of medical priorities with humanitarian values is echoed by William Muraskin in 'Hepatitis B as a model (and anti-model) for AIDS'. Muraskin sees a very clear historical lesson in the case of hepatitis B, a disease with some clear similarities – and differences – with AIDS. The scientific lessons were learnt from hepatitis B, argues Muraskin, but the social lessons were not. Hepatitis B remained a low profile disease and the problem of carriers of the disease was not dealt with, largely, in this interpretation, because carrier status affected health care workers. Concern about Asian immigrants and hepatitis B and about schoolchildren carriers were perceived as problems of discrimination. Muraskin castigates the policy decision to put the protection of the rights of carriers above the rights of the uninfected population. The result was a failure to generate solutions, such as safe sex, needed subsequently during the AIDS epidemic.

Although it deals with the 'pre-history' of AIDS, Muraskin's is a paper which draws a direct policy lesson. The second part of the book moves to the theme of AIDS itself as history – the 'contemporary history' of the past decade. Virginia Berridge in 'AIDS and British drug policy: continuity or change?' surveys the apparent changes which AIDS has brought in British drug policy. Many commentators have focused on the change to a health-based rather than a penal approach via the concept of harm-minimisation and the incorporation of drug policy within a public health paradigm. Berridge, while acknowledging the immediate reality of change, locates the shifts which have taken place within the context of tensions and concepts legitimised in drug policy since the late 1970s. Harm-minimisation was already the objective of a revisionist drug 'policy community'; AIDS gave the concept political acceptability. Berridge analyses current policy in the light of some continuing themes in drug policy; of medical legitimacy; the relationship between technological and policy change; and the long-term history of harm-minimisation as a guiding theme in British policy.

Warwick Anderson in 'The New York needle trial: the politics of public health in the age of AIDS' tells the very different story of US drug policy and in particular of the history of the attempt to establish controversial policy change in New York City. The attempt to secure the acceptability of needle exchange in New York was to be legitimised by a technical scientific procedure, that of the clinical trial. In Britain the apparent scientific neutrality of research – via the epidemiological assessment conducted by the Monitoring Research Group – did help secure controversial policy change. But the local limitations in New York on the role of expert groups meant that science did not have this autonomous authority. Anderson's aim is not to draw a 'lesson of history' from this; his paper does not discuss what might or should have been.

Victoria A. Harden and Dennis Rodrigues in 'Context for a new disease: aspects of biomedical policy in the United States before AIDS' also focus on US politics round AIDS, in this case the response of the federal research

organisations to AIDS. The authors use two case studies against which to contextualise that response. These are the establishment of the structure of the NIH system for distributing grants, and the emergence of targeted disease programmes and planning. The new concept of planning for research (a process which had its parallel in the UK with the Rothschild 'customer–contractor' changes) and of targeting specific diseases is illustrated via the politics of the response to DNA and to Legionnaires' disease. As Harden and Rodrigues note, the quick NIH response in that latter case may have heightened optimism around AIDS. But the research planning process proved useless in response to this new disease. Using internal documents, the authors survey the initial NIH reaction to AIDS and compare the changes required to those needed laboriously to re-direct a large ship already set on a particular course. They stress the importance of the mid-1982 move from an 'environmental agent' model to an infectious pathogen, and relate the stages of reaction to Charles Rosenberg's three-stage model of an epidemic.

Ewan Ferlie in 'The NHS responds to HIV/AIDS' has also had access to internal policy documentation. But his paper deals with the local dimension of policy making in British District Health Authorities. Ferlie, trained as an historian, writes from within a business school and from an organisation theory perspective. Many of the concepts are shared with historical ones, in particular the problem of organisational change over time, and the particular role of crisis in stimulating innovation. Here there is an organisation theory literature as well as an historical one. Ferlie delineates a cycle from innovation to institutionalisation which is also underlined by 'historical' work on AIDS. Managers, seen as key figures in National Health Service (NHS) policy at the local level in the 1980s, he finds 'dull' in relation to AIDS. Far more important were the clinical 'product champions', and the politics of the particular District were crucial where funding was concerned.

Ferlie's analysis of the District Health Authorities' response found new agendas being defined and a second generation of 'product champions' emerging as part of the move towards institutionalisation. John Street, in 'A fall in interest? British AIDS policy, 1986–1990' also deals with this later stage of AIDS, this time from a policy science perspective. Using the theme of 'crisis to complacency' as the normal pattern of response to pressing social policy issues, he uses AIDS as a case study to see if this model is indeed appropriate. Street scrutinises the issues raised by the 1987 Report of the Social Services Committee Enquiry into AIDS to see what has happened in the intervening years. He also examines the particular role of politicians and in particular of Mrs Thatcher as Prime Minister. The role of the All Party Parliamentary Group on AIDS is seen as important in maintaining consensus. The arrival of reform of the NHS on the political agenda also served to deflect attention from AIDS. Street concludes that the crisis–complacency model is too simplistic. Quite significant